Form Instructions
Notice of Medicare Non-Coverage (NOMNC)
"The Advance Notice"
CMS-10095-A

A MedicareAdvantage (MA) provider must deliver an advance, completed copy of this notice to enrollees receiving skilled nursing, home health or comprehensive outpatient rehabilitation facility services not later than 2 days before the termination of services. This notice fulfills the requirement at 42 CFR § 422.624(b)(2).

This is a standard notice. MA providers may not deviate from the content of the form except where indicated. (You may **modify the form** for mass printing to indicate the kind of service being terminated if only one type of service is provided, i.e., skilled nursing, home health, or comprehensive outpatient rehabilitation.) In situations where the termination decision is not delegated to the provider, the MA plan must provide the termination of services date to the provider not later than 2 days before the termination of services for timely delivery to occur.

The NOMNC should not be used when MA plans determine that an enrollee's services should end based on the exhaustion of Medicare benefits (such as the 100-day SNF limit). Instead, MA plans must issue the Notice of Denial of Medical Coverage.

MA plans and providers will note that the notice must be validly delivered. Valid delivery means that the enrollee must be able to understand the purpose and contents of the notice in order to sign for receipt of it. The enrollee must be able to understand that he or she may appeal the termination decision. If the enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by an authorized representative of the enrollee. Valid delivery does not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if an enrollee is able to comprehend the notice, but either is physically unable to sign it, or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting the use of such assistance. Furthermore, if the enrollee refuses to sign the notice, the notice is still valid as long as the provider documents that the notice was given, but the enrollee refused to sign.

Notice Delivery to Authorized Representatives

CMS requires that notification of changes in coverage for an enrollee who is not competent be made to an authorized representative acting on behalf of the enrollee. Notification to the authorized representative may be problematic because he or she may not be available in person to acknowledge receipt of the required notification. MA plans and providers are required to develop procedures to use when the enrollee is incompetent or incapable of receiving the notice, and the provider cannot obtain the signature of the enrollee's representative through direct personal contact.

- If the provider is unable to personally deliver a notice of noncoverage to a person legally acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered.

- The enrollee's appeal rights must be explained to the representative, and the name and telephone number of the appropriate quality improvement organization (QIO) should be provided.
- The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date.
- Place a dated copy of the notice in the enrollee's medical file and document the telephone contact to include: name of person initiating the contact, name of the representative contacted, date and time of the contact and the telephone number called.
- When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested.
- The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt.
- Place a copy of the notice in the enrollee's medical file and document the attempted telephone contact to include: the name of person initiating the contact, the name of the representative you attempted to contact, the date and time of the attempted contact and the telephone number called.
- When notices are returned by the post office, with no indication of a refusal date, then the enrollee's liability starts on the second working day after the provider's mailing date.

These procedures also may be used where an enrollee has authorized an individual to act on his or her behalf, and the provider cannot obtain the signature of the enrollee's representative through direct personal contact.

INSTRUCTIONS FOR CMS-10095-A PAGE 1:

Heading: MA plans and/or providers must be identified in this space. Logos may be used if they include the name of the organization, address and telephone number of the organization responsible for the termination decision above the title of the notice.

Patient Name: Insert the patient's full name.
Patient ID Number: Insert a unique patient identifier such as the HIC number or Medical Record number, if applicable.

THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT {insert type} SERVICES WILL END: {insert effective date}: Fill in the type of services ending, {**home health, skilled nursing, or comprehensive outpatient rehabilitation services**} and the actual date the covered service will end. The date should be in no less than 12-point type. Note that if the effective date for the service termination changes after delivery of the notice, the provider may contact the patient or authorized representative by phone to inform him or her of the new service termination date. Confirm the telephone contact by written notice mailed on that same date.

YOUR RIGHT TO APPEAL THIS DECISION

Bullet # 1 N/A
Bullet # 2 N/A

Bullet # 3 N/A
Bullet # 4 N/A
Bullet # 5 N/A

HOW TO ASK FOR AN IMMEDIATE APPEAL

Bullet # 1 N/A
Bullet # 2 N/A
Bullet # 3 N/A
Bullet # 4 Insert the name and telephone numbers (including TTY/TDD) of the applicable QIO in no less than12-point type.

INSTRUCTIONS FOR CMS-10095-A PAGE 2 - Signature page:

OTHER APPEAL RIGHTS

Bullet # 1 N/A
Bullet #2 N/A

ADDITIONAL INFORMATION (OPTIONAL)

This space is available, at the option of the plan or relevant provider, to furnish additional relevant information to the enrollee, such as further details about the reason for the service termination, or the timing of any additional liability risk. The use of this space does not replace the requirement to provide the Detailed Notice of Non-Coverage (DENC) to either the enrollee or the QIO when an appeal is filed.

Signature line: The enrollee or the authorized representative must sign this line.

Date: The enrollee or the authorized representative must fill in the date that he or she signs the document.